REQUIRED UNDER CHAPTER 702 (1999) –
"Health Care Regulatory Reform – Commission Consolidation"

Final Report on the Potential Merger of the Health Services Cost Review Commission and the Maryland Health Care Commission

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Final Report on the Potential Merger of the Health Services Cost Review Commission and the Maryland Health Care Commission

Chapter 702 of the Acts of 1999 (House Bill 995) requires the Maryland Health Care Commission (MHCC) and the Health Services Cost Review Commission (HSCRC), in consultation with the Maryland Insurance Administration and the Department of Health and Mental Hygiene, to study the "feasibility, desirability, and the most efficient method of reorganizing the duties and responsibilities" of the two commissions. A preliminary report was presented to the General Assembly on January 1, 2000. This final report contains specific recommendations pertaining to the consolidation of the two Commissions.

I. Introduction

Under the bill, the Chairmen and the Executive Directors of the MHCC and the HSCRC (executive committee) are responsible for the direct evaluation of feasibility and desirability of reorganization. Further, they are also asked to determine the best method of reorganizing the duties and responsibilities of the two commissions under one commission. To accomplish this task, the chairmen and executive directors were required to meet regularly, beginning October 1, 1999.

The first of these meetings was held in November 1999, and the members of the executive committee unanimously agreed that the General Assembly should delay consideration of further consolidation until the 2001 Session. The committee noted that the recent merger between the former Health Care Access and Cost Commission (HCACC) and the Health Resources Planning Commission (HRPC) has demanded much effort, and the final outcome of the merger, in terms of enhanced efficiency, has not yet been learned. Additionally, House Bill 995 commits the MHCC to evaluating the current certificate of need process and the HSCRC to the examination of the current hospital rate-setting system, two major Maryland health care regulatory initiatives.

In a second meeting occurring April 2000, staff presented a draft report that outlined the functional review of the two current Commissions and included an analysis of the potential benefits and costs of further consolidation.

The staff of the two commissions met regularly to discuss and outline the work plan that guided both the interim and final reports required under House Bill 995. The executive committee developed recommendations associated with regulatory consolidation, which were approved by the members of the two commissions.

II. Current Structure and Responsibilities of the MHCC and HSCRC

Organizational Structure of the MHCC

The Maryland Health Care Commission (MHCC) is organized into three main units: Data Systems & Analysis; Health Resources; and Performance & Benefits (see Appendix A – organizational chart). A deputy director, who reports to the Executive Director, heads each project. Under the authority of the Executive Director is the Executive Direction Division, which centralizes the key functions of budget, user fee assessment, procurement, personnel, and legal services. The Chief of Administration and Operations manages the day-to-day operation of the budget, user fee assessment, procurement, and personnel functions and provides the Executive Director with ongoing status report of activities within each functional area. The Legal Services unit, composed of three assistant attorneys general, provides advice to the Executive Director.

Functional Review of the MHCC

Data Systems and Analysis: Data Systems and Analysis is composed of four divisions that are responsible for the analysis, collection, and management of information on health care cost and utilization. One division is responsible for the creation and maintenance of the data bases collected by MHCC; the administration of all aspects of survey operation including software design, help desk operation, and quality control; and the development of specialized software in support of MHCC research and internet efforts. Another division is responsible for the preparation of the state health care expenditure and physician utilization reports that are mandated by law. The third division maintains the internal computer networks, monitors utilization of resources, enforces security measures and provides software support to MHCC staff. A fourth division promotes the adoption of electronic data interchange (EDI) for administrative health care transactions between Maryland providers and payers and also manages insurance companies' regulatory responsibilities on EDI and data reporting.

Health Resources: Three divisions develop components of the State Health Plan, which becomes a state regulation. These divisions are responsible for developing the State Health Plan with regard to: (1) Acute and Ambulatory Care Services (e.g., obstetrics, pediatrics, and ambulatory surgical services); (2) Specialized Health Care Services (e.g., cardiac surgery and therapeutic catheterization, neonatal intensive care unit services, and organ transplant services); and (3) Long Term Care and Mental Health Services (e.g., nursing home, home health, psychiatric services, and alcoholism and drug abuse treatment services). HB 995 provided that non-CON related planning functions be transferred from MHCC to the Department of Health and Mental Hygiene so that the Department could set global goals and undertake comprehensive health planning. The transfer included local health planning agencies. A fourth division administers the certificate of need program, a regulatory program that is based on standards, criteria, and methodologies developed through the State Health Plan.

Performance and Benefits: The three divisions reflect diverse projects that are unified by the common theme of providing information to consumers and employers to make the health care marketplace more competitive in terms of lower cost and increased quality. One division is responsible for monitoring the provision of coverage in the small employer market and an annual

evaluation of state mandated benefits which may impact the individual and large group markets. The second division is charged with collecting, and making available to the public, information to compare the performance and overall quality of commercial HMOs operating in Maryland. The third division responds to special requests for information on health care delivery system issues that are made by the Maryland legislature, executive departments, and other external groups and also serves as an incubator for newly mandated Commission activities, laying the groundwork for full implementation.

Organizational Structure of the HSCRC

The HSCRC is organized into two main functional areas: Research and Methodology and Rate Setting, with a deputy director heading each project (see Appendix B - organizational chart). Also under the direct authority of the Executive Director is the Legal Services unit, composed of two assistant attorneys general, and the Special Assistant to the Executive Director, who is responsible for managing the day-to-day operation of the budget, user fee assessment, procurement, and personnel functions.

As part of rate setting activities, the Commission collects a wide range of data from Maryland hospitals. This information falls into three major databases: financial data, inpatient medical records abstract data, and ambulatory surgery medical records abstract data. These data are used for a variety of purposes by the Commission, the Maryland Hospital Association, hospitals, and the public.

Functional Review of the HSCRC

Rate Setting: The Rate Setting Unit is comprised of three divisions which are responsible for audit and compliance, rate setting, and rate regulation for hospitals. Specifically, this includes the review and completion of all full and partial rate applications, processing of inflation adjustments, compliance with charge per case and unit rate targets, application of uncompensated care markups, and negotiation and monitoring of spend down agreements with hospitals. Rate Setting is responsible for initiating and recommending changes to on-going rate setting activities that are consistent with the Commission's mandates and changes within the hospital industry. The unit issues comfort orders, which are a statement by the Commission to the credit markets that the hospital should have sufficient revenue to meet its future debt service obligations. Finally, it examines CON application and exemption requests by advising the MHCC on the financial feasibility of hospital capital projects.

Research and Methodology: The Research and Methodology Unit contains three divisions consisting of program administration, special projects, and data processing. The Unit is specifically responsible for the coordination of all research and policy development activities of the Commission, including State and federal legislative relations. The staff conducts analytical studies of the payment system, quality and outcome measures, and related health policy matters. The studies permit the evaluation of any implications of proposed Commission and legislative policies on established hospital payment system methods, incentives/disincentives embodied in policy and practice, and hospital financial condition. Examples of these studies include: impact analysis of proposed changes to rate setting methods on hospital revenue and charge per case;

benchmark analysis of Maryland hospital performance along selected measures; evaluation of alternative mechanisms for equitably financing social costs such as hospital uncompensated care and graduate medical education; development of models to forecast industry performance; and research for development of alternative payment structures for integrated hospital delivery systems.

III. Feasibility and Desirability of Further Consolidation

The first step in examining the feasibility and desirability of further commission consolidation is to identify the areas of overlapping jurisdiction and mutual policy interests of the respective commissions. Determining whether duplication exists makes the decision to realign functions and the planning process of consolidation easier. If there is little evidence of duplicative activity, there is less reason to pursue further consolidation. Another consideration should be how well the two Commissions are currently functioning and whether they are making progress in achieving stated goals.

1998 Commission White Paper

In October 1998, the Health Care Access and Cost Commission/Health Resources Planning Commission (now the Maryland Health Care Commission, or MHCC) and the HSCRC issued a paper on regulatory reform. The document, which incorporated the ongoing efforts of the then three Commissions and the Department of Health and Mental Hygiene (DHMH), summarized the discussions of those regulatory initiatives that were underway prior to the 1998 legislative session and identified areas of consensus that were targeted for further reform. In the paper, the Commissions reaffirmed the trends of Maryland's health care market, which included: 1) an increasingly market driven health care system; 2) an increasing number of uninsured individuals; 3) continuing hospital excess capacity; 4) significant cost increases; and 5) greater demand for information and accountability from providers, payors, and regulators.

At the same time, the Commissions enumerated several goals for Maryland's health care regulatory system, including: increased access to care and cost containment; assuring accountability from providers, payors, and regulators; creating a system-wide financing of social costs; and encouraging the integration of health systems.

Specific initiatives were also outlined in the regulatory reform paper. These included:

- Transfer of state health planning functions to DHMH;
- Review of Certificate of Need (CON) requirements;
- Enhanced coordination of the small group market;
- HSCRC payment system reform;
- Creation of a limited service hospital; and
- Review and coordination of Commission data collection.

Progress on Identified Goals

Since the development of the 1998 paper on regulatory reform, the MHCC and HSCRC have made significant progress towards the goals established by the three original Commissions. As required under Chapter 702 of the Acts of 1999 (House Bill 995), the Health Care Access and Cost Commission and the Health Resources Planning Commission have since merged to create the MHCC. As part of the merger, the MHCC has transferred those state health planning functions that are not directly associated with the certificate of need process to the DHMH. A memorandum of understanding (MOU), due to be finalized in the Summer of 2000, is currently being drafted by the Department and MHCC to outline the specific responsibilities of each agency with regard to health planning. The MOU specifies the opportunities for participation of local health planning agencies in each agency's decision making processes, assures that comprehensive planning is centrally located within a unit of DHMH that is accountable to the Secretary, and provides for the sharing of planning data between DHMH and MHCC.

The new Commission has also committed itself to a thorough examination and recommended changes to current CON requirements by January 1, 2001 (see Appendix C – Work Plan for Examining the Certificate of Need Process). In addition, the MHCC worked with the MIA on an examination of whether shared oversight of the small group health insurance market is still an appropriate and efficient method of administration (see Appendix D – Evaluation of the Joint Administration of Maryland's Small Group Market by the MHCC and the MIA). The recommendations of the report are also being submitted to the General Assembly by July 1.

Additionally, the Maryland Insurance Commissioner and the Executive Director of MHCC were co-chairs of the "Task Force to Study the Non-Group Health Insurance Market," of which the HSCRC was also a member. As part of this study, the MHCC completed a demographic evaluation of Maryland's non-group and uninsured populations and provided detailed information regarding the dynamics of the state's small group health insurance market. As part of the Task Force's proposed recommendations, significant changes to the Substantial, Available, and Affordable Coverage (SAAC) program for the medically uninsurable were discussed with and offered to the General Assembly during the 2000 legislative Session.

The MHCC also continues to monitor the costs associated with proposed and existing small group health insurance mandates, provides an annual comparative performance report of health maintenance organizations for the general public, state employees, and health care policymakers, and is currently developing separate nursing home and hospital/ambulatory surgery facility report cards. These report cards are being developed in consultation with representatives from the HSCRC, the DHMH, and other interested parties.

As part of Chapter 678 of the Acts of 1999 (House Bill 994), a new licensure category for Maryland hospitals, defined as a limited service hospital, was created. Under the Act, a new methodology for calculating licensed bed capacity is calculated by the DHMH, which is required to delicense any beds in excess of this calculation by July 1, 2000. The HSCRC will then monitor this new licensed bed capacity as part of its current monthly hospital reporting requirements.

The HSCRC also worked during the fall and winter of 1999-2000 on the redesign of the hospital rate-setting system. Together with representatives from the hospital, payor, and business communities, and the MHCC and other regulators, the HSCRC held bi-weekly public meetings working to maintain the system of financing social costs, quality of patient care, and the appropriate level of equity and fairness in hospital payments, while keeping Maryland's cost performance in line with the nation. In February 2000, the HSCRC adopted the recommendations of the Committee and continues to work on design and implementation issues associated with each recommendation. These recommendations include simplifying the rate setting system design and reporting requirements, system-wide incentives that reward hospital efficiency, establishment of thresholds to monitor Maryland hospital cost performance, and, with representatives from MHCC, the exploration of a web-based claims process between hospitals and payors to enhance the efficiency of hospital claims payment in terms of accuracy and timeliness.

Areas of Continued Shared Interest

Under current law, the MHCC oversees the certificate of need process, the state health plan, development of the small group market and SAAC program benefit packages, performance report cards, and the provider encounter data system. The HSCRC regulates hospital rates, administers the SAAC differential to carriers who offer coverage to the medically uninsurable, and maintains hospital financial and discharge databases. Areas of shared interest include the coordination of data collection on hospitals and ambulatory surgery facilities, hospital capital projects, and the SAAC program.

Currently, the MHCC compiles its Uniform Hospital Discharge Abstract Database with the help of HSCRC monthly utilization data and, for non-acute care hospitals, data it obtains from the DHMH. Any additional information that is necessary is typically collected on an ad hoc basis by the MHCC**,** in consultation and discussion with the affected facilities and the HSCRC. Therefore, no duplication exists in the collection of hospital data between the two Commissions.

The MHCC's Freestanding Ambulatory Surgery survey instrument was designed with input from both the ambulatory surgery facilities and the staff of the HSCRC. The survey resolves both Commissions' data concerns and encourages the use of existing data. The two commissions also ensure complementary data collection of ambulatory surgery facility uncompensated care data by requiring hospitals to report uncompensated care figures specific to the hospital and any ambulatory surgery centers under HSCRC rate regulation. The MHCC, in turn, collects related uncompensated care data from freestanding ambulatory surgery centers, such that both regulated and unregulated data can be compared. Although the MHCC's hospital and ambulatory surgical facility report cards are still under development, it is anticipated that the quality indicators to be collected will not duplicate any information collected by the HSCRC. To assure that duplicate collection does not occur, the HSCRC is represented on the workgroup developing the report cards.

After a thorough review, no overlap currently exists between the two Commission's data collection efforts for hospitals and ambulatory surgery facilities. In addition, collection efforts are highly synthesized between the two Commissions, with discussions regarding new

collections efforts and dissemination coordinated between the Commissions and with other state agencies.

As described earlier, the HSCRC analyzes comfort order and CON requests, issues comfort orders, and determines the financial feasibility for CON exemptions and applications for hospital capital projects. The analysis is developed by the HSCRC, using information collected by the HSCRC, the MHCC, and the hospital, and is utilized throughout the CON process by all parties. To ensure that regular communication occurs between the MHCC's certificate of need staff and the HSCRC rate-setting staff monthly meetings are held to review all pending projects. In this way, both Commissions assure not only financial feasibility, but also coordinate policy with regard to such vital issues as excess bed capacity.

Finally, the HSCRC participated on the "Task Force to Study the Non-Group Health Insurance Market," co-chaired by the Insurance Commissioner and the Executive Director of the MHCC (Chapter 602 of the Acts of 1999). The Act instructed the Task Force to make recommendations as to whether changes should be made to state laws governing the non-group health insurance market, taking into account and examining issues related to the SAAC program. The MHCC and the HSCRC worked collaboratively on recommended changes to the SAAC program, which were presented to the General Assembly for consideration during the 2000 legislative Session. As before, any future changes to the SAAC program would be done in consultation with the Maryland Insurance Administration.

In addition to the specific activities outlined above, the MHCC and HSCRC are working to assure coordination at all levels of their organizations by sharing the minutes of Commission meetings, sending representatives to each other's monthly meetings and exchanging new reports prior to their public release. Commissioners or staff are also invited to update their sister agency on a regular basis at monthly meetings.

IV. Should Further Consolidation Occur?

In determining whether to recommend further consolidation, the executive committee addressed several key questions, including:

A. How much functional duplication currently exists between the MHCC and the HSCRC?

As stated above, areas of shared interest include data coordination, ambulatory surgery, hospital capital projects, and the SAAC program. An analysis of these areas demonstrates that no duplication exists in the collection of hospital and ambulatory surgery facilities data between the two Commissions. The two Commissions also serve two disparate functions with regard to hospital capital projects with a high degree of coordination in effort. The MHCC and the HSCRC worked together on the Task Force to Study the Non-Group Health Insurance Market which, for its preliminary report, primarily addressed the SAAC program. In addition, both Commissions work collaboratively on the SAAC program, with the MHCC having primary responsibility for the redesign of the benefit plan and the HSCRC

establishing the size of and basis for the differential.[1]

B. What are the potential administrative, budgetary, and other efficiencies that could result from consolidation?

Research on consolidations has demonstrated a merger seldom results in reducing costs significantly. Potential administrative savings could be determined by examining the merger of the HCACC and the HRPC. According to estimates provided by the MHCC, the consolidation resulted in a reduction of administrative costs of about $400,000. The majority of these reductions ($300,000) stem from the transfer of local health planning functions to DHMH. Since, in the future, local health planning costs will need to be paid out of general funds to the Department they do not really reflect "overall savings" to the state government. In terms of organizational size, the merger has not offered an opportunity to eliminate any positions. The administrative units of the two Commissions were reorganized into one unit. However, because the responsibilities of the MHCC did not decrease, the need for administrative support has remained stable. The $100,000 of administrative savings came from a reduction in operating expenses (e.g., telephone charges, rent [$40,000], and Commissioners' per diems). The administrative savings, not including the trends associated with the transfer of local planning functions, account for less that 1.5 percent of MHCC's total budget.

C. Can part-time volunteer Commissioners sufficiently oversee the functions and responsibilities of a consolidated MHCC and HSCRC?

The MHCC and the HSCRC have concluded that it would be very difficult for a consolidated Commission to oversee the activities of the two existing Commissions without significantly restructuring how the Commission conducts its business or increasing its size. This is primarily due to the increased demands that would be placed on Commissioners rather than staff.

As noted above, the current functional duties of both of the Commissions are very extensive with virtually no overlap. After the October 1, 1999 consolidation, MHCC Commissioners were required to be familiar with issues related to health planning, the regulatory oversight of certificate of need, health insurance policy, data collection, electronic data interchanges, and performance evaluation reporting. The HSCRC Commissioners must be well versed in the intricacies and details of the hospital rate setting system and the impact of those rates on the overall health care system. In addition, the HSCRC Commissioners must have a thorough understanding of alternative rate methodologies, comfort orders, financial feasibility studies, data collection, hospital consumer concerns, and hospital risk sharing arrangements.

Currently, the Commissioners of both Commissions serve on a voluntary basis. Because the time demands on these Commissioners are kept to a minimum of one to two meetings per month, the Commissions have been able to secure Commissioners who play diverse and important roles in the community. Commissioners have included the former president of

[1] The authority of the HSCRC to alter or eliminate the SAAC differential has been temporarily placed on hold, pending the signing of Senate Bill 855 from the 2000 legislative Session.

Johns Hopkins University, a vice president of CareFirst, hospital presidents, Ph.D. economists, and the Dean of the University of Maryland Medical School, as well as community activists, labor leaders and consumers. There is a general sentiment that increasing the workload under a consolidated HSCRC/MHCC Commission would force the current volunteer Commissioners to rethink their commitment. It is very likely that a voluntary Commission would no longer be feasible, as time demands on Commissioners would be dramatically increased with such a consolidation or that duties would fall disproportionately on those Commissioners who had fewer demands on their time.

The meeting agendas of both Commissions are extensive (see Appendix E) with meetings sometimes lasting six hours and an average of six to seven topics per meeting. In addition, some Commissioners are expected to preside at special public meetings regarding changes to rate-setting system, the benefit plan for the small group market, and CON issues.

A wide range of knowledge is required of Commissioners within each respective Commission. It is unrealistic to expect that voluntary Commissioners would be able to devote the additional time and energy that would be necessary to gain an even more comprehensive background to effectively and knowledgeably make decisions on an expanded range of subjects. The alternative to governance by volunteer Commissioners is paid staff who are full-time Commissioners. This would add another layer of bureaucracy and cost to the consolidated Commission, while also stripping the Commissioners of their independence from any state-regulated personnel system. Paid commissioners could lack the objectivity and general knowledge of the business world the current Commissions regulate. Further, realistic compensation levels would not attract Commissioners of the same caliber as the current volunteers that serve on both Commissions.

D. Do the benefits of consolidation outweigh the potential costs of disruption to current activities of the two commissions?

The two Commissions conclude that the very minor administrative savings that potentially could be realized with a consolidation of the two Commissions do not outweigh the potential costs that would be incurred by such a merger. While minimal administrative and budgetary savings could potentially be realized, the cost of moving the two Commissions to a location where they could be located in one physical space could offset those potential savings given the experience of the previous consolidation where the administrative savings of consolidating the HCACC and the HRPC were less than 1.5 percent of the total MHCC budget.

More importantly, a consolidation, at this time, would disrupt the current activities of the two Commissions that are critical to the future of the health care system in Maryland. The MHCC is just now becoming able to effectively address functional policy issues that have arisen with the 1999 merger of the HCACC and the HRPC, including issues related to the certificate of need process, state and local health planning, and potential changes to the small group market. The HSCRC continues to work on the design and implementation of the issues that were brought forth by the hospital rate-setting redesign process.

In addition, the impact on the Commissioners themselves that such a merger would incur could either alter the makeup of the Commission itself by dissuading community leaders that have served as Commissioners in the past because of increased demands of time and effort. The wide range of policy areas for which a combined Commission would be responsible could also lead to decision- making based on inadequate knowledge or information and greater reliance on staff. This could lead to a less active, "rubber stamp" role, to the detriment of Maryland's historic regulatory success.

Finally, the Commissioners believe that the benefits of the current structure with the two Commission's acting as a check and balance on each other's activities should be considered if merger is contemplated in the future. The current structure provides the opportunity for each Commission to review and comment on the other's decisions thus providing an opportunity for greater diversity of opinion and a mix of perspectives on health issues.

E. Are there means other than consolidation that can accomplish the goals of reducing functional duplication, administrative and budgetary savings, and increasing policy coordination? If so, in what areas could policy be better articulated to achieve coordination between the MHCC and the HSCRC?

There are a number of mechanisms already in place to assure communication between state agencies involved in all aspects of the delivery of health care. The Governor's Health Policy Council consisting of the Deputy Chief of Staff for the Governor, the Secretaries of the Department of Budget Management, Department of Health and Mental Hygiene, Office of Aging, the Maryland Insurance Commissioner and the Executive Directors of the Maryland Health Care Commission and the Health Services Cost Review Commission meets every two weeks. Further, Chapter 702 (1999) requires the Chairman of both Commissions and their Directors to meet quarterly.

As has been demonstrated, there is very little functional duplication in the duties of the HSCRC and those of the MHCC. Nearly all of the complaints of the overlap and conflicting regulation with the former three Commissions were resolved by merging the HCACC and the HRPC. The remaining two Commissions each have as much scope as they can effectively manage, and work smoothly together. Efforts toward coordination of data collection and data sharing, however, should continue. These include attending each other's monthly meetings, sharing minutes of meetings and reports and meeting on a regular basis to discuss CON issues to assure policy as well as functional coordination regarding excess capacity in the future.

V. Conclusion

A. <u>The Two Commissions Should Not Be Merged At This Time</u>**:** For reasons cited in Section IV, the Commissions recommend that no further consolidation should occur. If the staffs of the two Commissions were merged, some slight administrative savings might be realized. However, since functions are not reduced and there is no duplication of function, no real savings related to functional changes would occur. Most importantly,

the burden of such a combined workload on volunteer Commissioners would serve to deter persons of the caliber of a university dean, hospital president, or world-class economist. A combined Commission would require voluntary Commissioners to have a broad range of expertise however, all decision making would occur with the same time frames as exist today within each separate Commission. A decrease in the relative amount of time for deliberations could lead to increased dependence on staff recommendations or decisions based on insufficient information.

While both MHCC and HSCRC are currently confronted with major health initiatives to complete, the validity of the decision not to merge and the effectiveness of coordination efforts should be reevaluated periodically as the health care delivery system evolves. The evaluation should include an assessment of each Commission's progress in defining goals and carrying out statutory mandates as well as coordination of function and policy between the two commissions. Any discussion of merger should also carefully consider the benefits of the current structure in providing a check and balance on the activities of each Commission by creating an opportunity for joint review with regard to CON applications and in other areas of shared interest rather than concentrating decision-making into one Commission.

B. Maintain and Improve Coordination: The meetings mandated by Chapter 702 (1999) should be continued to assure the coordination of the duties of both Commissions. The two Commissions have cooperated in all of the projects that affect both of them. In the areas of shared interest, including data coordination, ambulatory surgery, hospital capital projects, and the SAAC program, staff should continue to work collaboratively as they have in the past. Although the relationship of the MHCC and the HSCRC with other state agencies has not been the focus of this report, it is clear that linkages need to be maintained with agencies such as the Maryland Insurance Administration to assure system-wide coordination of policy. The actions of both Commissions should continue to be shared with all state agencies that impact on the health of Marylanders through the Governor's Health Policy Council.

APPENDIX A
(AVAILABLE UPON REQUEST)

APPENDIX B
(AVAILABLE UPON REQUEST)

APPENDIX C

WORK PLAN FOR EXAMINING
THE CERTIFICATE OF NEED PROCESS

Section 11(d)(1) of House Bill 995 (1999) requires the Maryland Health Care Commission (MHCC) to develop priorities, a work plan, and a process for reviewing major policy issues related to the certificate of need (CON) process during calendar years 2000 and 2001. This report addresses which CON-related services have been prioritized for examination during each calendar year and a template defining the examination process/report outline for each group of services. In addition, a general study of the approval process for granting certificate of need should be considered.

I. Introduction

To begin the study of the CON process, the genesis and purpose of the CON program will be examined with particular attention to assessing the future Maryland health care environment and the role of public oversight. There are two possible methods for examining the CON program: (a) by looking at specific services or facilities for which a CON is required to determine if changes are needed; and (b) by examining the procedural rules used by the CON program using a systemic approach. It may be logical to use parallel tracks to separately pursue these two methods for examining the CON program so clear goals can be maintained for each method.

II. Issue Priorities and Time Frames: Specific and Systemic

Specific Services/Facilities: Due to the major differences between acute care/hospital related services and long term care services, and the complexity of the issues in each of these major categories, they will be addressed separately.

- *Acute and Ambulatory Care Services:*
  - Specialized hospital services (including cardiac surgery, NICU, organ transplant, and rehabilitation services)
  - General hospital services
  - Ambulatory surgery services

- *Long Term Care, Mental Health, and Other Services:*
  - Home health
  - Hospice
  - Comprehensive care
  - Residential treatment centers
  - Mental health and substance abuse services
  - Other services

Within the acute and hospital related services component of the study, priority will be given to studying specialized hospital services and obstetrical services in calendar year 2000. Other general hospital services and ambulatory surgery services will be targeted for

study during 2001. In the second component, comprehensive care, home health, and hospice services will be studied during calendar year 2000. During the following year, residential treatment centers, mental health, substance abuse, and other services regulated by the CON program will be reviewed.

CON Process Procedural Rules: There are various interested organizations who believe that the entire process of gaining a CON approval or an exemption from the CON, should be examined. As such, an examination of the procedural rules that govern the CON process in general should be addressed in addition to the examination of the CON program for a specific service/facility. This section would include several paragraphs describing the CON review process, in general, and a timeline for how this examination would go forward.

III. Process Utilized to Examine Priority Issues

Specific Services/Facilities: This section lays out the general template that both defines the topics to be covered in each study and outlines the contents of the reports that would result.

- *Purposes of a specific CON Program in Maryland*

  Describe the law; the State Health Plan review criteria and standards; scope of regulations pertaining to that specific service/facility; history of major regulatory changes.

  Discuss perceived strengths and weaknesses of current CON program for that specific service/facility.

- *Examination of Policy Issues* (uses results of previous examinations as well as the current examination process)

  Effectiveness of existing CON program for a specific service/facility– Has it accomplished its intended goal? What has been the result? How have its purpose and the relevant aspects of the marketplace changed since the law was instituted?

  Alternatives to existing CON program for a specific service/facility - Examine possibilities in re-regulation; deregulation; evidence of free market competition and control; and oversight via licensing. Cite other states' experiences where relevant.

  Relationship of CON program for a specific service/facility to other regulatory efforts – such as regulatory oversight by the Office of Health Care Quality, hospital rate regulation, and the assurance of quality.

- *Conclusions and Policy Recommendations*

  CON Process Procedural Rules: This section lays out the general template that both defines the topics to be covered and outlines the contents of the report that would result. The general format of the study of the CON process procedural rules would be similar to that framework used for the examination of a specific service/facility.

- *Purposes of the CON Process in Maryland*

  Describe the law; scope of regulations pertaining to the CON process in general; history of major regulatory changes

  Discuss perceived strengths and weaknesses of current CON program in general.

- *Examination of Policy Issues* (uses results of previous examinations as well as the current examination process)

  Effectiveness of existing CON process in general – Has it accomplished its intended goal? What has been the result? How have its purpose and the relevant aspects of the marketplace changed since the law was instituted?

  Alternatives to existing CON process in general - Examine possibilities in re-regulation; deregulation; evidence of free market competition and control; and oversight via licensing. Cite other states' experiences where relevant.

  Relationship of CON process in general to other regulatory efforts – such as regulatory oversight by the Office of Health Care Quality, hospital rate regulation, and the assurance of quality.

- *Conclusions and Policy Recommendations*

The Role of Technical Advisory Committees: For each of the tasks outlined above, it is anticipated that the Commission will form a technical advisory committee of interested organizations to aid in its examination of issues related to the CON process regarding specific services and facilities. The membership of the committee would differ for each examination of the CON program for a specific service/facility. In addition, a committee with broader representation would be desirable for the examination of the overall CON program and procedural rules. Staff support will be provided by the MHCC. Technical advisory committee reports will be made available for public comment through either a public hearing or over the Commission's website depending on the subject of the study and the number of organizations affected. All reports will be approved by the Commission prior to submission to the General Assembly.

APPENDIX D

EVALUATION OF THE JOINT ADMINISTRATION OF MARYLAND'S SMALL GROUP INSURANCE MARKET BY THE MHCC AND THE MIA

Introduction

Section 11(d)(4) of House Bill 995 (1999) requires the Maryland Health Care Commission (MHCC) to list its priorities, approximate time frames and process for examining major policy issues. This paper is presented to partially fulfill this requirement by addressing the administration of the small group health insurance market. Specifically, the paper focuses on whether the joint administration of the small group market by MHCC (formerly HCACC) and the MIA is still an appropriate and efficient method of administration and how coordination between the two agencies could be strengthened to reduce the reporting burdens on insurance carriers.

This paper provides the basis for public comment on the administration of the small group health insurance market from various stakeholders. The report is organized as follows:

I. Background
II. MHCC's Activities
III. MIA's Activities
IV. Issues for MHCC and MIA
    A. Linkages and Communication
    B. Regulatory Coordination
    C. Responsiveness to Stakeholders
    D. Data Collection Requirements
V. Recommendations

I. Background

The MHCC's regulatory authority stems from legislation passed in 1993 House Bill 1359, Chapter 9, Acts of 1993 ("Maryland Health Insurance Reform Act") requiring its predecessor commission, the HCACC, to undertake certain insurance reforms. The Health Insurance Reform Act was intended to reform marketing practices in the sale, issuance, rating, and renewal of health insurance to small employers. Prior to 1993, the health insurance market for small employers in Maryland was not working well and employers who had just one employee with a pre-existing condition had trouble purchasing insurance coverage. Insurers were avoiding risk rather than accepting and managing it. The HCACC's enabling legislation required the Commission to develop a benefit package for small employers with benefits that are at least equivalent to a federally qualified HMO and an average premium that does not exceed 12 percent of Maryland's average annual wage in any year. Working with this statutory floor and ceiling, the legislation also directed the Commission to adopt regulations specifying a comprehensive standard health benefit plan (CSHBP) to apply under Maryland insurance law (Health General § 19-108). The Insurance Code defines Maryland's small group market as employers with 2 to 50 eligible employees. In implementing the legislation of 1993, the Governor appointed the Maryland Standard Benefit Plan Task Force, which developed the

regulations for the CSHBP by November 1, 1993. The regulations also require the Commission to review the CSHBP annually (Insurance Article 15, Subtitle 12).

The Task Force presented its report to the Commission in November 1993, and regulations were promulgated and finalized in April 1994, with an effective date of July 1, 1994. Carriers participating in the small employer market can only offer a policy incorporating the CSHBP on a guaranteed issue, guaranteed renewal basis. Medical underwriting was phased out as of January 1, 1995. Riders can be issued to improve the benefits but not to diminish them. The insurance reform required community rating adjusted only for age and geography. Rating bands were established eventually at plus or minus 50 percent, decreasing to 40 percent, then frozen at 33 percent rather than decreasing to 16 percent as the original legislation specified. After numerous requests from carriers and brokers, the 1999 General Assembly reset the community rating bands at 40 percent, effective June 1, 1999.

During the 1995 legislative session, the small group market was expanded to include self-employed individuals who filed Schedules C or F with their federal income tax. This expansion became effective July 1, 1996. During the 1997 legislative session, the General Assembly clarified the definition of "self-employed" to include all persons deriving a significant portion of their income from self-employment, as documented by any appropriate tax form. Additionally, the 1997 General Assembly passed legislation stating that if an employer-client of a Professional Employer Organization (PEO) met the definition of small employer, then the employer-client would be subject to small group market reform. Then, in 2000, the General Assembly revised the definition of self-employed requiring the self-employed person to work and reside in Maryland. It also revised the definition of small employer so that the count of eligible employees is based on the preceding calendar quarter. It also deletes the portion of small employer definition that permits groups of one. These three changes became effective on June 1, 2000.

II. MHCC's Activities

Overall, MHCC has responsibility for the annual review and updating of the CSHBP, while MIA focuses on daily enforcement of the insurance reforms. Organizationally, oversight of the small group market is located under the Deputy Director for Performance and Benefits in MHCC. Activities relating to administration of the CSHBP are carried out by a Division Chief for Benefits Analysis and a health policy analyst. A consulting actuary also is on contract with the Commission.

The MHCC's legislative mandate required the Commission to develop a comprehensive standard health benefit plan (CSHBP) with guaranteed issuance, guaranteed renewability, modified community rating, and no pre-existing condition limitations. At a minimum, benefits must be the actuarial equivalent of those offered by a federally qualified HMO. In addition, the average cost of the standard plan must remain less than 12% of Maryland's average annual wage. If the 12% affordability cap is reached, benefits must be reduced or out-of-pocket expenditures increased. Finally, the benefit structure of the CSHBP must be similar to existing benefit plans offered to large employers.

The Commission's activities reflect a cyclical process of benefit plan review. Annually, the Commission is charged with conducting a review of the standard benefit plan to measure the average cost of the plan in relation to the average wage and to maintain the minimum mandates of a federally qualified HMO. Another component of this annual review requires the Commission to consider suggested benefit modifications. Some of these are generated from the yearly session of the Maryland General Assembly (i.e., the passage of legislation relating to mandated benefits and other health insurance issues); and, others are requests by various stakeholders to simplify the administration of the standard benefit plan, alter benefits, or adjust the out-of-pocket cost structure of the plan. Since the CSHBP is exempt from state mandated benefits, the Commission must act affirmatively to adopt any mandates.

During the first period of operation of the CSHBP, the Commission worked with its consulting actuaries to compile the necessary data and develop a formula to meet the statutory obligation of assuring that the average cost of the standard benefit plan is less than 12% of Maryland's average annual wage. The Commission adopted a formula to calculate the average cost of the standard benefit plan per employee. This formula requires Commission staff to collect from each carrier participating in the small group market specific data elements relating to each delivery system that the carrier offers to small employers. Currently, six delivery systems exist in this market:

- Indemnity
- PPO (Preferred Provider Organization)
- POS (Point-of-Service)
- TPOS (Triple Option Point-of-Service)
- HMO (Health Maintenance Organization)
- PPO/MSA (PPO with a Medical Savings Account)

Regulations were promulgated to mandate timely filing of this information to Commission staff. Specifically, survey forms containing the following data must be submitted by all carriers for each delivery system by family composition by April 1 of each calendar year: number of small employer groups, number of lives, number of policies, member months, premiums written, premiums earned, claims incurred, expenses incurred, loss ratios, and expense ratios.

Prompt filing is critical to the Commission's annual review cycle. To ensure that these timelines are maintained, the Commission adopted COMAR 10.25.05.04 to impose a fine of $500 per day on any carrier submitting a survey after the April 1 deadline.

The annual financial survey submitted by each carrier provides the Commission with the relationship of the average cost of the plan per employee to the average wage (See Appendix 1, for a summary of carrier financial experience in 1999). Additionally, the survey allows the Commission to determine if insurance reform is working as intended. The data indicate, for instance, the changes in the number of employers purchasing group insurance, the number of lives covered including dependents of employees, and changes in enrollment within the various delivery systems.

From the inception of small group reform through calendar year 1998, the results reveal favorable growth in employers offering insurance as well as the number of lives covered, indicating that the reform efforts in Maryland are, in fact, working. In 1999, employer groups rose another 8 percent, but the number of covered lives fell by 2.63 percent. The decline in covered lives was due primarily to a sharp decrease in enrollment in three HMOs. The data also show significant movement from the higher cost delivery systems (indemnity and PPO plans) to the more affordable POS and HMO options through 1998. In 1999, both indemnity and HMO enrollment fell, but the other managed plans experienced growth. Prior to 1999, the shift to lower cost plans had a positive effect on keeping the average cost of the plan below the statutory affordability cap.

After analyzing the financial data collected from carriers, the Commission's consulting actuary uses this information to determine actual costs for a particular calendar year and projected costs for the next two years. Maryland's Department of Labor Licensing and Regulation ("DLLR") provides similar estimates for the average wage. Together, these figures can be used to calculate the ratio of average cost to average wage. This information is critical to the Commission during its annual review of the CSBHP when it considers adding or modifying benefits in the standard benefit plan. The consulting actuaries estimate the impact of all proposed benefit changes. Next, the Commission, keeping in mind its obligation to maintain affordability in the CSHBP, adopts any benefit changes at its September public meeting (See Appendix 2 for an example report. Results of the annual review for calendar year 1999 will be available in September). Proposed regulations to implement the changes made are reviewed by the Commission at its October public meeting. Regulations are finalized by the March Commission meeting, leaving time for carriers to adjust their contracts prior to the effective date of the changes, which is July 1. Regulations are promulgated jointly with the MIA (See Attachment 1 for timeline).

III. MIA's Activities

The MIA's obligation in the small group market is to assure compliance with regulations affecting small group insurance contracts. The Health Insurance Reform Act of 1993 requires the Insurance Commissioner to review a carrier's premium rates and loss ratios, obtain actuarial certification of financial information, and review contracts for compliance with the requirements of the CSHBP. These requirements apply to all insurance carriers operating in Maryland's small group market. The legislation also requires the MIA to establish a Maryland Small Employer Health Reinsurance Pool.

The enforcement of the small group market laws and regulations affects several sections of the MIA. The Life and Health Section is responsible for form review and market conduct. The Office of the Chief Actuary is responsible for the review of the premium rates. The Life and Health Unit of the Consumer Complaint Investigation Section is responsible for the investigation of consumer complaints. A brief discussion of each of these MIA responsibilities in the small group market follows.

A. Rate Review

Before an insurer, nonprofit health service plan or HMO (carrier) can begin to market a product in Maryland, the premium rates must be filed with and accepted by the Office of the Chief Actuary to ensure that the rates are not excessive, inadequate or discriminatory. If the carrier wants to increase the premium rates, the rates must be filed and accepted by the MIA prior to use in Maryland.

B. Form Review

Products sold by the participating carriers in the small group market also are reviewed to assure that the contracts conform to the CSHBP regulations.

Whenever new CSHBP regulations are adopted by MHCC, MIA staff reviews the regulations to minimize any misunderstanding in applying them. MHCC timelines are designed to ensure that regulatory changes are finalized by March 1 to allow sufficient time for participating carriers to submit and for MIA to review the contract amendments so that the July 1 effective date is achievable. However, even the March 1 date allows insufficient time for filing rates and forms, obtaining necessary approvals, revising marketing materials, and meeting statutory deadlines for renewal notices to be issued for July 1 renewals.

When MIA staff, in dealing with carriers, agents, brokers, and beneficiaries has problems interpreting the wording of the CSHBP, recommendations are made to MHCC to help clarify specific coverage issues and ease administration of the contracts.

C. Consumer Complaints and Inquiries

As a service to policyholders, beneficiaries and claimants, and as a means of checking the compliance and performance of insurance companies, agents, and brokers, the Life and Health Inquiry and Investigation Unit of the Consumer Complaint Section investigates complaints and requests for information about policy contracts. Throughout the early years of small group market reform in Maryland, both the MIA and MHCC staffs have received numerous requests for information. Many issues have been resolved through frequent communication between staffs of both organizations. However, ultimately, MIA staff has the authority and responsibility of enforcing the regulations and the law. Typical inquiries from agents and brokers often include requests about marketing practices and benefits coverage.

D. Market Conduct

Staff of the Market Conduct Unit examines insurance carriers, HMOs, agents, and brokers to review their underwriting, sales and advertising, rating, and claims handling activities. With roughly 700 carriers in the Life and Health arena, it is obvious that MIA cannot visit all carriers each year. Generally, the MIA reviews each carrier domiciled in Maryland on a three-year cycle, unless specific complaints or situations warrant more frequent investigation.

In addition to the regular three-year cycle review of carriers domiciled in Maryland, the MIA has performed a number of targeted market conduct examinations on small group carriers in the State. The market conduct examination is directed only at the compliance issues applicable to the small group market and includes the proper identification of the small employers, the proper offerings of the small group plans and additional benefits, and the proper advertisement of the self-employed coverage. The target market conduct examination also determines compliance with the guarantee issuance and guarantee renewal requirements, as well as the use of approved premium rates.

IV. Issues for MHCC and MIA

Having outlined the statutory responsibilities and activities of MHCC and the MIA, the remainder of this paper will address the following issues: current linkages/ease of communication; regulatory coordination; responsiveness to stakeholder issues; and data collection requirements of these two agencies.

A. Current Linkages/Ease of Communication

The MHCC and its predecessor commission have worked closely with the MIA since the inception of the CSHBP. The MIA supported the Commission in staffing the Standard Benefit Plan Task Force that developed the CSHBP in 1993. Particularly, the MIA provided expertise with respect to the structure and administration of health insurance contracts.

In 1995, the MHCC's predecessor commission executed an MOU (Memorandum of Understanding) with DHMH, HSCRC, and the MIA calling for at least quarterly meetings of key staff members. It also was agreed that a key staff person would attend Commission meetings to keep apprised of any activities regarding the small group market.

Numerous examples can be cited of the ongoing communication between the two agencies. In 1998, when the Commission decided to undertake a survey of businesses participating in the small group market to determine their satisfaction with the reforms, the MIA was asked to review and comment on the survey instrument and was provided the results of the report that was produced. MHCC, its predecessor, and the MIA have jointly staffed several workgroups to resolve small group market issues, including the application of HIPAA requirements (1997); the inclusion of professional employer organizations (1997); and most recently a Prescription Drug Advisory Committee (PDAC) to develop a three-tier prescription drug formulary as part of the CSHBP effective July 1, 2000. MHCC and the MIA have served on each other's selection committees for contracts for actuarial services, and on committees for selection of key personnel. Communication also occurs to coordinate each agency's position on any legislation affecting the operation of the small group market.

B. Regulatory Communication

The MHCC annually reviews and modifies the CSHBP through the regulatory process. As described in section II of this paper, the review includes assuring that the average premium

remains within the affordability cap, and evaluating the actuarial impact of enacted or proposed mandated benefits and stakeholder suggestions to determine their potential impact on premiums if included in the CSHBP. Once the Commission has decided what changes to make in the benefit package, MHCC staff consults with MIA staff on the appropriate wording of regulations to effect the changes. MIA has an opportunity to review or revise all proposed regulations. Ultimately, these regulations are jointly promulgated, meaning that they are approved by both the Chairman or the Executive Director of MHCC and the Maryland Insurance Commissioner.

While this dual promulgation process is somewhat unusual in state government, it has, in general, worked smoothly. Initial delays in promulgation caused by an unavailability of one or both signers have been resolved by allowing for substitute signatures from each agency. Moreover, involving both agencies in the drafting of regulations early on in the process has eliminated some delays that were caused by last minute changes to the regulations. In short, both agencies have learned to work comfortably with each other in this process. Every effort is made to complete the promulgation process by March of each year to assure that MIA has sufficient time to review contracts for compliance prior to the July 1 date when they become effective.

C. Responsiveness to Stakeholder Issues by MHCC

The original benefit structure of the CSHBP and its subsequent modifications are largely due to significant input from a variety of stakeholders: consumers, providers, employers, and carriers. The Commission considers all stakeholder suggestions as part of its annual review of the CSHBP. After each proposal has been analyzed by the Commission's actuarial consultant to ascertain its fiscal impact and a public hearing has been held, a staff report with recommendations requiring adoption is presented to the Commission. Any proposal approved by the Commission is then incorporated into the CSHBP by either a change in law or by regulation.

Attachment 2 is an example of stakeholder issues presented to the Commission for consideration between 1996 and 1999. As the attachment shows, the Commission considers about 3 or 4 stakeholder issues each year, in addition to discussing the inclusion of mandated benefits into the CSHBP. Many of the stakeholder issues are raised by agents and brokers seeking to improve access to insurance coverage in the small group market. For example, in 1999, the Commission considered raising the deductible in the PPO plan at the suggestion of the broker community. At the suggestion of a carrier, the Commission convened a work group to determine whether a formulary should be required as part of the pharmaceutical benefit in the CSHBP. Occasionally, suggestions for change also come from legislators who may have a coverage issue raised by a constituent that was not discussed as part of proposed legislation during the previous Legislative Session.

In addition to direct input into the CSHBP, stakeholders also are encouraged to provide comment on any proposal before the Commission through the public hearing process. Each year, the Commission holds at least one public hearing on proposed changes to the CSHBP, apart from its regular monthly meetings. MIA also is requested to comment at this juncture. Stakeholders also are encouraged to comment during the regulatory promulgation process, which lasts 45 days.

Finally, the Commission has responded occasionally to stakeholders'concerns by seeking changes in the law. In 1997, the Commission sought a change in the definition of a "self-employed" individual because the original definition excluded individuals who were incorporated in limited liability corporations, professional associations, or other legal arrangements.

The CSHBP has been modified to increase/modify benefits, clarify coverage, adjust deductibles and/or out-of-pocket limits, and add two delivery systems. To date, because of the favorable ratio between the average cost of the plan and the average wage, no benefits have been totally eliminated from the plan.

D. Responsiveness to Consumer and Carrier Issues by the MIA

The MIA, as the entity that enforces the requirements of the small group laws and regulations, has constant interaction with carriers and consumers.

In 1998, the deductibles for the indemnity plan and PPO small group standard plans increased. The MIA received a number of consumer complaints that carriers had increased their deductibles without informing them of the changes. In response to the consumer complaints, the MIA required the carriers who failed to give the notice of changes to the plans as required by §15-1212 of the Insurance Article, to continue to provide benefits as if the deductibles had not changed.

The small group regulations, COMAR 31.11.07, require that the carriers advertise an open enrollment for the self employed twice a year, during the months of June and December. The MIA has cited several companies for failure to comply with these requirements. Some companies have paid administrative penalties for these violations, while others have agreed to provide additional open enrollment periods for the self-employed.

The MIA discovered two companies that were not observing the guarantee issuance requirements of the small group market, §15-1209(b) of the Insurance Article. Both John Deere Insurance Company and Metropolitan Life Insurance Company chose to withdraw from the small group market and pay administrative penalties, rather than comply with the guarantee issuance requirements.

E. Duplication of Data Collection

There is duplication between MHCC and the MIA in some data collection activities. This is largely the result of the distinct functions of the two organizations and their needs for the data to carry out their duties.

The Office of the Chief Actuary of the MIA requires an annual submission of a report entitled, *"Maryland Annual Health Benefit Plans Report."* See Attachment 3 for a copy of the 1999 Report. During the early years of small group market reform, the MIA collected the general data from participating carriers listed in the top portion of Attachment 3. Note that carriers reported their small group market data under one category for all delivery systems. However, beginning 3

years ago, the MIA expanded its data collection, requiring carriers to include summary data for each delivery system in accordance with legislation enacted in 1996 (See bottom portion of Attachment 3).

The following data are collected in the small group market by both MHCC and the MIA: number of policies; number of certificates; number of insureds; premiums written; premiums earned; claims incurred; and expenses incurred. The MIA has expanded its collection of expenses incurred and also collects detailed information on commissions, general expenses, taxes, licenses, and fees. Additional data collected by MHCC from small group carriers that is not collected by the MIA includes family composition (individual, employee plus one, family) as well as detailed information on member months (See Attachment 4).

Under MIA law and regulations, carriers are required to submit the data on the *"Maryland Annual Health Benefit Plans Report"* to the MIA by March 1 of each year. Failure to report this information timely could result in a $500 fine imposed by the MIA. More than 900 forms are mailed out to all carriers licensed to sell health insurance in Maryland, including the carriers participating in the small group market. The MIA does not have a statutory or regulatory deadline in place for a completed analysis of the data. However, in general, carriers submit all completed forms by the end of March.

The actuarial division of the MIA utilizes the data to generate reports within the regulatory responsibility of the Insurance Commissioner. For example, the MIA uses the specific data collected on the small group market to monitor a carrier's loss ratio. Section 15-605(c)(1) of the Insurance Article gives the Commissioner the authority to require a small group carrier to file new premium rates if the loss ratio for the small group coverage is less than 75%. The data also are used to observe trends in costs and enrollment.

Although it appears that the MHCC's financial survey now duplicates much of the data being collected by the MIA, it is important to keep in mind that the two data collection activities historically evolved separately. Initially, the MIA did not collect information on each individual delivery system in the small group market, until required to do so by 1996 legislation. This information always has been collected by MHCC because knowing the enrollment and premiums in each delivery system is critical in managing the affordability of the benefit plan.

Since the two data collection activities are more similar now than when they began, it may be possible to reduce some of the duplicated effort. However, in merging any data, the statutory requirements of both MHCC and the MIA must be kept in mind. The results of the annual financial survey conducted by MHCC are critical to the annual review of the affordability of the CSHBP. For that reason, the Commission imposes fines and penalties on carriers for late submissions. The analysis of the financial results must be completed by late May or early June in order for the Commission's actuaries to evaluate the impact of proposed changes to the CSHBP. The MIA, while on a similar time schedule, does not have the urgent need for the analyzed data that the MHCC has since its use of the information is to monitor compliance of individual carriers rather than look at the health of the small group market in aggregate. In order to merge any data collection activities, the needs of both groups for timely information would need to be recognized and penalties put in place for late reporting.

Since §15-605 of the Insurance Article requires the MIA to collect premium and expense information from all carriers, there would be no savings on the part of the small group carriers by sending the small group information currently collected by the MIA to MHCC. Section 15-605 would still require these carriers to complete the same form for coverage the carriers sell in other than the small group market.

Overall, the duplicative financial reporting requirements do not appear to have been overly burdensome to carriers and have not been raised as a major issue by stakeholders. If the duplicative collection activities of MHCC and the MIA cannot be reduced, it may be possible to at least use the dually collected information to "audit" what is reported separately to each agency. This would allow for a check on the quality of the data reported.

V. Recommendations

(1) Maintain the current arrangement of shared responsibility between MHCC and the MIA for the small group health insurance market.

An analysis of the small group market over the past six years since the reforms became effective indicates the market is working well overall. Based on data reported by participating carriers, the number of covered lives increased about 18% between 1995 and 1999, to almost one-half million persons. The 2.63% decline in coverage overall can be attributed principally to a decrease in HMO coverage, particularly among three HMOs. Decline in HMO coverage is a phenomenon being experienced nationally. The Commission and the MIA will need to pay close attention to this indicator of access in the future. The number of employer groups offering coverage also increased from 43,595 in 1995 to 58,495 in 1999. About 50 percent of small employers in Maryland now offer coverage, as compared to 40 percent prior to small group market reform. Although the number of carriers has declined, much of this has been a result of consolidations and mergers of carriers and the exit of indemnity carriers from the market due to declining enrollment. Most importantly, the current administration of the CSHBP has permitted the average plan premiums to remain under the statutory affordability cap.

The bifurcation of responsibilities between MHCC and the MIA has allowed MHCC to set broad policy for the marketplace while the MIA provides strong enforcement of market requirements. The MHCC, as an independent Commission, has been able to manage the benefit plan, resisting political pressures to either increase or reduce benefits. Although exempt from the mandated benefit law, the Commission has systematically examined each of the mandates passed or proposed during the previous legislative sessions as well as promptly responded to stakeholder issues. The Commission has both added some benefits and reduced some coverage in the CSHBP over time. As a consequence, the average premium in the small group market for calendar year 1999 remained below the affordability cap, at 88.19%. Although premiums rose about 10 percent in1999, these increases were comparable to the experience of other small and large group markets, as cost and use have increased. [2,3]

[2] Mercer/Foster Higgins, "National Survey of Employer-Sponsored Health Plans, 1999;" Medical Benefits, 17: January 15, 2000.

MHCC and the MIA have established good communication in review and promulgation of regulations impacting the CSHBP. In fact, the finalization of regulatory changes to the plan has been completed earlier each year, allowing carriers more time to adjust. However, MHCC and the MIA should commit to a final adoption of changes by January 31 of each year.

Further, MHCC and the MIA have worked well together in resolving issues arising in the small group market on eligibility, benefit coverage, and compliance. The joint staffing of workgroups convened, as needed, has allowed for communication on both broad policy and actual implementation of decisions made. Both agencies also have been responsive to stakeholder concerns and have developed a systematic way to address changes annually rather than making more frequent changes that are more difficult to monitor for compliance.

(2) Explore whether reduction in the duplication of data collection is feasible or whether data collected by each agency could be used to "audit" results.

Given the distinct duties and responsibilities of each agency and its use of data collected, it is not clear whether the data collection process could be streamlined without jeopardizing the functioning of MHCC and the MIA. Nonetheless, a group should be convened to explore this option since data collection timelines are similar and, over time, the data collected has become more duplicative. If data collection efforts cannot be simplified, ways to use the data collected by each agency to "check" the information reported by carriers for accuracy should be considered.

(3) The appropriateness and efficiency of joint administration of the small group market by MHCC and the MIA should be reviewed periodically.

The Commission and the MIA should examine periodically the administration of the small group market identifying any problems in communication or responsiveness and developing means to correct them.

[3] "The InterStudy Competitive Edge HMO Directory, 10.1:" Medical Benefits, 17: May 15, 2000.

APPENDIX E
(AVAILABLE UPON REQUEST)